U.S. Department of Health and Human Services
Administration for Children and Families

OMB Control No. 0970-0125
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U.S. REPATRIATE PROGRAM

Privacy Act Statement

The U.S. Repatriate Program provides funds for financial, medical, transportation and other assistance to individuals who are certified by the Department of State as repatriates in need. This assistance must be repaid to the U.S. Government by the repatriate. Section 1113 of the Social Security Act authorizes the collection of the information solicited on these repatriation forms for the purpose of determining your eligibility for such assistance.

The Department may disclose this information to other Federal, State or private organizations, if necessary to enable the Department of Health and Human Services to carry out its responsibilities under Section 1113 of the Act, or to enable another Federal agency to carry any functions related to your return from a foreign country and entry into the United States, or as otherwise expressly authorized by the Assistant Secretary for Children and Families. Furnishing the information on these forms is voluntary; however, if you fail to provide the requested information, such failure may result in your being found ineligible for repatriation assistance.

Repayment Agreement

I understand that all financial, medical, transportation and other assistance provided to me through the Repatriation Program must be repaid. I understand that I will be billed by the United States Department of Health and Human Services for the cost of this aid, and I agree to repay this amount in full. Repayment in full or my first installment payment is due 30 days after billing. If I pay by installment, or am delinquent in repayment, interest at the current rate fixed by the Secretary of Treasury for private consumer loans will accrue on the unpaid portion. Until I repay in full the aid received, I agree to report all changes in my address to the Department of Health and Human Services, Administration for Children and Families, ORR/DSLR, 370 L'Enfant Promenade SW, Washington, DC 20447, Attention: Repatriation Branch.

Name (print) Last _____ First _____ MI _____

Address _____

_____

Social Security Number _____ Phone Number _____

I understand and agree to all terms and conditions of the Privacy Act Statement and the Repayment Agreement, and certify that the information provided by me is correct.

Signed _____ Date _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration
Office of Family Assistance

ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES
Expenditure Statement and Claim for Reimbursement

(1) NAME OF AGENCY	STATE	FOR THE PERIOD From: , 20	To: , 20

THE FOLLOWING EXPENDITURES HAVE BEEN MADE BY THIS AGENCY FOR ASSISTANCE TO A UNITED STATES CITIZEN RETURNED FROM A FOREIGN COUNTRY. ASSISTANCE AND SERVICES HAVE BEEN PROVIDED IN ACCORDANCE WITH THE POLICY AND PROCEDURES PRESCRIBED FOR THIS PROGRAM.

(2) CASE NAME (FIRST NAMES OF MAN AND WIFE, IF A COUPLE):	NO. OF PERSONS:

REPATRIATED FROM (COUNTRY):	CURRENT ADDRESS

(3) A. CLASSIFICATION/AUTHORITY PUBLIC LAW 86-571 (MENTALLY ILL) ☐	C. EXPENDITURES
SECTION 1113, SOCIAL SECURITY ACT (OTHER THAN MENTALLY ILL) ☐	MEDICAL CARE $
B. NATURE OF THIS ACTION: INITIAL CLAIM ☐	HOSPITALIZATION $
INTERIM CLAIM ☐	NURSING HOME $
ESTIMATED FUTHER CLAIMS $ _____	MAINTENANCE $
1. DATE CASE CLOSED	TRANSPORTATION $
2. REASON CASE CLOSED	FOSTER CARE $
3. REPAYMENT RECOMMENDED ☐	OTHER (SPECIFY) $
4. WAIVER RECOMMENDED ☐	TOTAL $

(4) DESIGNATION OF STATE OFFICIAL AUTHORIZED TO RECEIVE FEDERAL FUNDS AS REIMBURSEMENT OF THIS CLAIM

TITLE	ADDRESS

(5) THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT PAYMENT FOR THESE EXPENDITURES HAS NOT BEEN RECEIVED.

SIGNATURE OF OFFICIAL OF AGENCY	TITLE	DATE

Form SSA-3955 (7-81)
Use prior editions

Distribution: Original + 2 copies to SSA Regional Commissioner, not later than 15 days following the close of the month.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration
Office of Family Assistance

ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES - REPORT ON REFERRAL

CASE NAME	COMPOSITION		BIRTH DATE OF FAMILY HEAD	SS NO.
	NO. ADULTS	NO. CHILDREN		

LAST U.S. RESIDENCE	DATE LEFT US

CURRENT ADDRESS

REPATRIATED BY DEPARTMENT OF STATE FROM:	BECAUSE OF:
	☐ MENTAL ILLNESS ☐ DESTITUTION ☐ INTERNATIONAL CRISIS ☐ OTHER ILLNESS (DIAGNOSIS, IF KNOWN)

DISPOSITION

ARRIVED U.S. (DATE)	DHHS REFERRAL RECEIVED (DATE)	INITITAL AGENCY CONTACT (DATE)

(1) FINANCIAL ASSISTANCE AUTHORIZED	DATE OF INITIAL ASSISTANCE	☐ ONE MONTH OR LESS ☐ MORE THAN ONE MONTH

TYPE OF ASSISTANCE	(A) AMOUNT - FIRST MONTH	(B) ESTIMATE - NEXT MONTH
MAINTENANCE	$	$
TRANSPORTATION		
HOSPITAL		
NURSING HOME		
OTHER MEDICAL		
FOSTER CARE		
OTHER (SPECIFY)		
TOTAL		

RESOURCES AVAILABLE TOWARD CURRENT NEEDS ☐ YES ☐ NO

(2) FUTURE PLAN	CHECK: WILL NEED ASSISTANCE UNTIL THE FOLLOWING RESOURCES WILL BE AVAILABLE →	NUMBE OF MONTHS ASSISTANCE NEEDED
	☐ OWN OR RELATIVE ☐ EMPLOYMENT ☐ INSURANCE ☐ SSI ☐ ANOTHER PUBLIC PROGRAM ☐ OTHER	

(3) RECOMMENDATION AS TO REPAYMENT OF ASSISTANCE GRANTED

(a) WILL BE ABLE TO REPAY ☐ ONE PAYMENT ☐ INSTALLMENTS DATE

(b) WAIVER RECOMMENDED (REASON)

(c) ABILITY TO REPAY NOT DETERMINED (REASON)

COMPLETED BY	TITLE

STATE	DATE

Form SSA-2061 (7-81) Distribution - Original + 2 copies to Regional Commissioner, SSA within 5 days of initital contact

Department of Health and Human Services
Administration for Children and Families
Office for Refugee Assistance

Repatriation Program
Consent Form

I, _____, authorize the
(Print)
Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office or Refugee Resettlement (ORR), Repatriation Program (Program), to collect and have access to my protected health information (PHI)and to disclose my PHI to appropriate Program contractor/s, partner/s for the purpose of making Program Financial Decisions (PFD). PFD includes but is not limited to waivers and loan collection decisions.

Authorizing HHS/ACF/ORR/Program to collect, have access to and disclose your PHI information is volunteer. However, without your authorization, HHS/ACF/ORR/Program may be unable to proceed with your request and/or make a PFD decision regarding your case. We collect this information under the Privacy Rule authority issued pursuant to the Health Insurance Portability and Accountability Act of 1996.

REPATRIATION PROGRAM
INTERNATIONAL SOCIAL SERVICE/AMERICAN BRANCH
REFERRAL FORM

Date:

To: Contact Person — Fax: Contact person fax #

From: ISS-USA Case worker

Post Requesting Action: — Country

Case Name: — Repatriate Name

Case Number: — 0000-0000

1. Birth Date/Place of Birth: — 01/01/1901/USA
2. Passport #: — 123456789
3. Next of Kin: — Name of kin(s) and contact information

4. Privacy Act Waiver: — Yes or No

5. Assistance Requested: — Choose all that applies:

1- Arrange temporary shelter and transitional housing

2- Arrange for an emergency mental health evaluation and if needed, psychiatric hospitalization and/or outpatient follow-up treatment

3- Arrange for an emergency evaluation of alcohol abuse for impatient and/or outpatient follow-up treatment.

4- Arrange for a medical evaluation and if need, hospitalization and/or outpatient follow-up treatment.

5- Arrange for a rehabilitation facility or nursing home for NAME which is appropriate for the medical care.

6- Arrange for medical and mental health evaluations within first several days of arrival.

7- Attempt to locate family or friends of NAME in the area

8- Upon arrival at the airport, meet NAME and escort and assist them with transfer to continuation flight

9- Upon arrival at the airport, meet NAME and provide transportation to a temporary shelter or transitional housing

10- Provide social services for resettlement including application for appropriate and eligible entitlements

11- Contact local adult protective services to asses NAME situation including risk of abuse and neglect.

12- Arrange for medical and mental health evaluation to determine if NAME has the ability to care for himself

13- Have local department of social services contact NAME to asses the child protective issues surrounding the case.

14- Investigate other family placement willing to accept the child

15- Arrange for foster care if no other placement options exist for this child

6. Date Departed USA:	01/01/1901
7. Last US Address:	unknown/list address given
8. Final Destination:	Resettlement State
9. VA/SSN:	123-45-6789
10. Arrival Information:	Travel Itinerary
11. Remarks:	Background information on Repatriate

Thank you for your assistance.

Sincerely,

ISS-USA Case Worker Name
(Job title)